Systems Transformation Grant Strategic Planning Meeting
January 23 – 24, 2006

Session 1 – Statewide Primary Care Case Management (SOURCE):

- ***What will be the greatest challenge in adapting the SOURCE model in Arkansas?***

  - Case Manager – Quality
  - Community networking
  - Information and where to go
  - Need strong community ties
  - Training
  - MD involvement in teams
  - Buy-in for community, providers, MD marketing campaign
  - More resources, legislative support, nursing home resistance – Georgia chain
  - Standards, strict so need a lot of providers
  - Medical director should be local – need to find a Medical "champion"
  - Evaluation indicators, financial, cost beneficial/effective
  - Inadequate infrastructure within clinics to monitor quality
  - Lack of Managed Care experience
  - Providers opposition
  - Research and evidence to prove a good program
  - MD response, right medications
  - Financial incentives for MD participation, reimbursement to cover costs
  - Conflicts between SOURCE and HCBS monitoring w/ Providers
  - MD power issues, no official PCP
  - Nursing home opposition
  - Specialty care coverage
  - How to identify individuals
  - DD population, dual eligibility
  - Age minimum concrete (65)

- ***Do individuals typically go to one doctor for all their care?***

  - Connect care <65 – Do have a physician
  - Some duals may not , others have multiple MDs
  - PCPs refer but don't "manage" care and medications
  - PCPs rely on self-reports of Rxs = Limited management
  - Most people may go to one for basic care, but may go directly to specialist, communication a concern
  - People with multiple MDs may not know who their PCP is
  - Yes for "health" aging services, no for DD or mentally ill
  - Availability when needed – Individuals go to a number of physicians at any given time which include specialists in different areas, sometimes they go to the one who can see them the quickest
  - What if they want to keep their old doctor?

- MD capping # of Medicaid patients
- Convincing people to use PCP
- PCP does not manage care
- PCP may not really be managing the health care
- Depends on demographic location, rural areas are more likely to see one doctor, in larger areas have better access w/ multiple doctors

- ***Because this will be a voluntary PCCM program, what are the most effective ways to convince consumers and physicians to participate?***

  - Demonstrate CMs ability to assist MDs
  - Need to address benefits to the MD and consumer (help to navigate system)
  - Explain how it will help consumer stay at home
  - Will the rate be enough to make it worthwhile for MDs?
  - Current PCCM – MD does see all members every month
  - Provide incentives
  - Demonstrate benefits through statistical analysis of increase in improved health
  - Get respected MDs to do PR
  - Don't just accept consumers that have minimal problems
  - Make sure we are able to deliver services before the program gets started
  - Help consumers understand they get a MD and a CM
  - Build respect w/ MD and CM
  - MDs - Better care, greater control over all medical care, help in case management, more knowledgeable about all medical concerns (drugs, etc.)
  - Patient – Someone to help w/ all your health care needs (navigate the system easier) an advocate for the patient
  - Could build practice of primary physician
  - Dr. Sumner presentation along with other states who have successfully implemented the program
  - Educate about program benefits
  - Participant testimonies
  - Small $ incentive to consumer $5 – $10 month
  - Use current waiver participants for consumers
  - Use current case managers who are aware of interest among MDs
  - Provide good coordinated care

Session 2 – Information Technology:

- ***What are the most important considerations for planning technology that will be used by waiver participants and applicants?***

  - KISS
  - Extremely user friendly (especially for consumers)
  - Access to computers
  - Live human touch (Voice, Reassurance)
  - Tech considerations around actual users
  - People need to know advantages, payoff

- Where and how available and who can help (AARP, etc)
- Applications accessible and easy to understand
- Telephone answered by live, knowledgeable person
- Reasonable timeline for assessment and follow-up
- Co-accessing data
- What advantage to elderly that don't use internet
- IT to connect case managers to individual service vendors to facilitate delivery and management of services, How?
- If IT is for the participant, will it be for eligibility or for info?
- Different ways to access system (on-line, phone, walk-in)

- ***What will be the greatest challenge in developing and implementing web-based common applications for waiver programs? How can we best overcome those challenges?***

  - Info common to all waivers (Smart Apps – skip questions) so need all potential info
  - Hard to get agreement, but decision trees help
  - Basic info, but need case worker follow up for more
  - Costs in relation to scope (amount) of info
  - One home for the data
  - Agreement of agencies on content for application form
  - Back up document issues (bank statements, payroll stubs, rent)
  - Can consumer make a selection on-line that allows info to be shared by a stakeholder
  - Minimum common info needed by all the different programs
  - Professional follow-up for more detailed questions to determine which specific program they qualify for
  - Need a moratorium on all new client forms until you decide on a common form
  - How and what info will be shared, who can make that decision
  - How simple, broader is harder to implement
  - HIPPA restrictions, sharing of information
  - How to enter follow-up information

- ***What will be the greatest challenge in developing and implementing web-based common assessments for waiver programs? How can we best overcome those challenges?***

and

- ***What will be the greatest challenge in developing and implementing web-based plans of care for waiver programs? How can we best overcome those challenges?***

  - Use new "uniform common" form (MDS-HC Dick Wyatt has developed software for new waiver, look at WA, Rosalie Kane Study, and RTZ)
  - Costs for changing
  - Who can change it
  - Those who use data for care planning, must trust data they get

- Timeliness
- Create historical database – changes to “master” that are related to care plan must be supported by assessment.
- Track cost data with assessment and services (management reports)
- Develop what we need and not more than that (KISS)
- Getting agencies to agree on the data
- Tie the assessment process and plans of care together
- Avoid duplication of effort – the entity developing plans of care will have to have acceptance of assessment info
- How do we get the plan into a web-based with all the necessary info and not have them look like the same plan for everyone
- Who can change the data
- Emphasize consumer direction by enabling consumers to participate in service referral, service budgeting and service coordination to speed the delivery of services, do we want to?, what do we need to do to effect consumer direction?, how do we enable consumers?
- Use SW Arkansas as a laboratory to integrate state nurses and local case managers, information and increase consumer direction, what steps would it entail?
- Client/server model with a laptop or table may work in rural homes
- Integrate info between state nurses and local case managers to facilitate the processing and delivery of services, is this desirable? how do we?

Session 3 – Quality Management:

- ***Regarding the plan to combine three current waiver (ElderChoices, Alternatives for Adults with Physical Disabilities, and Living Choices/Assisted Living) into one “super waiver”, what are the major considerations to which DHHS should pay attention?***

  - If waivers are combined, what might be lost? Ex. Home modifications reduced if spread across all waivers
  - No loss of service for any group
  - Effect on providers
  - How to bring advocacy groups together
  - Make sure can combine with similar criteria and services
  - Cost factors when waivers are combined
  - Will services be limited due to cost
  - Assume eligibility is more generalized for all waivers
  - Make sure a targeted population is not lost in the consolidation
  - Buy in by special interests
  - Do an 1115 Waiver
  - Objective is to make it transparent to the client
  - Get understanding and consensus from the 3 waiver programs
  - Resistance from current entitlement program if getting the 1115
  - Will application and assessment process be combined and leave waiver programs as separate pots of money

- One name
- Why not add DD waiver for adults
- Make simplistic so all can understand

- ***What is the most effective way for DHHS to share information about waiver quality (such as Quality Management Reports) with key stakeholders, including consumers?***

  - Post on web, advertise
  - Send quarterly postcard w/ site or # for printed copy
  - Use vehicles of other organizations, ex. AARP newsletter
  - Use AARP, senior centers, case managers for dissemination
  - Display expected outcomes in annual report w/status
  - AAA, AARP, Senior Centers, Case workers, media
  - Not too much info for consumers
  - Highlights
  - 1 – 4 pages
  - Respondents want to see results
  - "Branding" of report to make it recognizable
  - Post on website and send to stakeholders
  - Problem w/ lack of addresses or don't understand, post sample to get results
  - Use a report card format on web-site
  - Info to senior centers, advocacy groups
  - Case managers can report to beneficiaries and consumers
  - Get info to AARP, AAA to distribute in their communication vehicles
  - Easy to read charts
  - Individual mailings
  - Postcard to stakeholders with a link and phone number to receive printed results
  - Advertise web availability

- ***What is the easiest way for consumers to provide feedback to DHHS about the quality of waiver services?***

  - Quality system for periodic consumer surveys phone/mail/focus groups
  - Direct mail – simple form w/return envelope
  - How about people who don't get into the system? Ex.: AR-GetCare – was it useful? And how about people who leave waiver for NF?
  - Random sample, statistically significant
  - CMs encourage providers to get feedback
  - Annual review
  - Independent organization/process
  - Involve consumers
  - Add to tool, how best to obtain feedback, preferred way to be contacted
  - One to one conversation by phone
  - Independent 3rd party evaluations by a peer
  - Capture specific quality measures w/ a measure of outcome
  - Semi annual or annual survey of those denied services or sent to nursing homes

Session 4 – One Stop:

- ***Are there good components of the current service access system we need to keep or incorporate into the "One Stop" system?***

  - Keep AAA, county DHHS, ILCs
  - AR Get Care
  - Magnolia pilot
  - Nurses – CM for Elderchoices (ESP for SOURCE)
  - Expertise for different populations, automatic flags to experts, designated experts available
  - Local
  - Not replacing ILCs, AAA, etc
  - Additional place to call
  - Use technology populating records (efficiency)
  - At least connect to experts
  - Start the Medicaid application process
  - Opportunity to create standard for call centers
  - Objective information and assistance
  - Most effective way to report DHHS, back to consumers
  - Census – w/ specific outcomes captured, colorful report card
  - Need to be sure that we have expertise
  - Get calls to the right person, agency at that time
  - Develop a SOURCE program in Arkansas

- ***What are the most effective ways to establish linkages with community providers, physicians, etc. to support and use the "One Stop" system?***

  - Marketing plan and budget
  - Presentations
  - Continuous advertisement
  - Give MD a different toll free phone number
  - Posters – grocery stores
  - AMFC (QI0) partnership
  - Contract with commercial call center
  - SOURCE
  - Hospital discharge planners
  - Publish One-stop, send mail-outs
  - Be responsive when the provider calls
  - One-stop is accessible

- ***What are your two top recommendations for developing and implementing who should receive immediate help?***

  - Want to leave institution
  - Immediate health risk; bedfast, can't eat
  - Lack of support system
  - Client in danger of injury, crisis

- Nurse visit to determine criteria

- ***The "One Stop" will be highly automated but with live support by telephone. What are the most important things for the staff to know or do to be of most help to callers?***

  - Great assessment tool – linked to programs and services
  - People who really understand system
  - Need to listen to whole story
  - Is person in crisis?
  - Listen for underlying concerns
  - Access to data on current participants
  - Sensitivity, listening and speaking skills
  - Knowledge of eligibility
  - Access to AR-GetCare.com
  - Important things for staff to know services and providers in detail, have a good directory
  - Be aware of private pay services
  - Be very familiar with services toll-free numbers to the AAA
  - Courteous, knowledgeable staff
  - Follow-up, do what they say they will do
  - Keep option on automation to a minimum and simple
  - Caring staff with good interpersonal skills
  - Have some ability to assess if they need immediate intervention
  - Good assessment tool w/decision tree